Exhibit 69

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF NEW YORK, et al. Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	Case No. 1:25-cv-00196

DECLARATION OF JANE DOE 3

I, Jane Doe 3, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct:

1. I was employed by the Division of Reproductive Health (DRH), part of the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) within the Centers for Disease Control and Prevention (CDC). I have personal knowledge of the facts set forth in this declaration, and if required to testify, would and could competently do so.

2. I am submitting this declaration pseudonymously because I fear retaliation. But if the Court would like to know my name or job position, I would be willing to provide it ex parte and under seal.

3. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

Professional Background

4. I have worked in public health for over 35 years, of which 20 of those years were in DRH.

5. I am providing this declaration to explain the impacts of the reductions in force (RIFs) of April 1, 2025, on the operations of DRH. The April 1 RIFs have brought much of DRH's work to a halt. These impacts will be felt by the states as well as by their residents, as DRH will no longer be able to perform vital surveillance activities on maternal and infant health outcomes, in vitro fertilization (IVF), abortion, and contraception safety, nor will DRH be able to continue its field work to provide direct assistance to states through assignment of senior maternal and child health epidemiologists and capacity building to address the needs of reproductive-aged, pregnant, and postpartum women and their infants for an emergency response, such as a pandemic or natural disaster.

DRH's Mission and Work Prior to April 1, 2025

6. DRH has been dedicated to improving women's health, maternal health, and infant health for nearly 60 years, aiming to enhance the lives of women, infants, and families through science, data, and partnerships. DRH aims to combat preventable maternal mortality and morbidity and ensure optimal birth outcomes across the nation. Programs within DRH provide crucial data and data analysis as well as resources to empower state and local jurisdictions to monitor health behaviors and outcomes, guide program and policy evaluation and development, and implement tailored solutions. These data-driven approaches strengthen community initiatives, promote healthy families, and improve the well-being of women and infants.

7. DRH's priority areas are to:

a. Improve infant health outcomes and care;

b. Improve maternal health outcomes and care; and

c. Eliminate preventable maternal mortality.

8. DRH is made up of several subdivisions, including the Office of Director and three branches: Maternal and Infant Health Branch, Women's Health and Fertility Branch, and Field Support Branch.

9. The Office of Director is responsible for science, policy, partnerships, and communication activities for the division and includes a Division Director, Associate Director for Science, and an Associate Director for Policy, Partnerships, and Communication. The Associate Director for Science supervises DRH's Senior Health Economist, Health Services Lead, and Informatics Lead. The Associate Director for Policy, Partnerships, and Communication supervises the Communication Lead and the Policy Lead.

10. The Maternal and Infant Health Branch (MIHB) leads efforts to reduce health problems and death among mothers, newborns, and infants through robust data and surveillance and implementation of quality improvement interventions. The Maternal and Infant Health Branch includes three teams: Maternal Mortality Prevention Team, Perinatal and Infant Health Team, and Maternal Health and Chronic Disease Team. The Maternal and Infant Health Branch's activities are authorized by Congress in the Safe Motherhood Act, 42 U.S.C. § 247b-12, Preventing Maternal Deaths Act (Pub. L. 115-344), and Scarlett's Sunshine on Sudden Unexpected Death Act (Pub. L. 116-273). Since 2016, CDC has worked with state and territorial health departments to enhance measurement and provide better data on maternal mortality in the United States via the Enhancing Reviews and Surveillance to Eliminate

Maternal Mortality (ERASE MM) initiative. ERASE MM directly funds maternal mortality review committees (MMRCs) in 46 states and 6 U.S. territories to obtain detailed data on maternal mortality cases through standardized, high quality and faster data collection. Because of the ERASE MM program, the number of operational MMRCs nearly doubled between 2015 and 2020. Findings from MMRCs indicate that 80% of pregnancy-related deaths are preventable; therefore, MMRCs also develop actionable clinical and non-clinical recommendations for the prevention of maternal mortality. The Pregnancy Mortality Surveillance System (PMSS) is a national system that has provided comparable data across the United States for over 30 years on pregnancy-related deaths. In alignment with ERASE MM and PMSS work, CDC also funds 36 state Perinatal Quality Collaboratives (PQCs) and the National Network of PQC; these clinical partnerships with PQCs implement quality improvement efforts to address the prevention recommendations from MMRCs to improve obstetric and neonatal care and outcomes in a state or region based on local priorities and data. The Branch also supports the Sudden Unexpected Infant Death (SUID) Case Registry in 32 jurisdictions, which compiles data to provide a better understanding of circumstances and risk factors among SUID and to develop strategies to reduce future deaths, and also funds enhanced SUID prevention activities in 10 selected communities.

11. The Women's Health and Fertility Branch (WHFB) conducts surveillance and research and implements programs aimed at improving reproductive health, fertility, and pregnancy outcomes. The Women's Health and Fertility Branch includes three teams: Pregnancy Risk Assessment Monitoring System (PRAMS) Team, Fertility Epidemiology Studies Team, and Assisted Reproductive Technology Surveillance and Research Team. The Branch's activities are congressionally authorized by the Safe Motherhood Act, 42 U.S.C. §

247b-12, the Prematurity Research Expansion and Education for Mothers who deliver Infants Early Act (PREEMIE Act), Pub. L. 109-450, and the Fertility Clinic Success Rate and Certification Act of 1992, Pub. L. 102-493. Key activities in the Women's Health and Fertility Branch include:

a. **PRAMS:** PRAMS was established in 1987 by Section 317K of the Public Health Service Act, also known as the Preventing Maternal Deaths Act of 2018 (P.L. 115-344), to reduce maternal and infant mortality and morbidity by monitoring maternal experiences behaviors and experiences before, during, and shortly after pregnancy. The PRAMS team works directly with 50 jurisdictions (46 states and 4 cities/U.S. territories) to provide scientific and technical support for continuous, year-round data collection (e.g., survey development, data collection system infrastructure, standardized methodology, and data processing and weighting) and publishes annual data and reports for public use. The data represents approximately three million live births annually in the United States. PRAMS is the only standardized state-specific data source for maternal and infant health and is crucial for informing programs and public health policies at the state and national levels aimed at improving maternal and infant health. PRAMS data are used by states for needs assessment and as performance and outcome measures for the Health Resources and Services Administration (HRSA) Title V Maternal and Child Health Block Grants and by academic and other researchers to investigate emerging maternal and infant health issues.

b. **Surveillance of contraception safety and contraception guidelines:** The Branch supports healthy pregnancy planning and the prevention of teen and unintended pregnancy by providing essential, up-to-date, and evidence-based clinical contraception guidelines for health care providers on safe and effective use of contraceptive methods (*U.S. Medical Eligibility Criteria for Contraceptive Use* and *U.S. Selected Practice Recommendations for Contraceptive Use*). Based on continuous evidence identification and rigorous methodology, these are the only federal guidelines on the safety of contraceptive use for women with certain medical conditions and characteristics and help providers and patients make safe choices for pregnancy planning and pre-pregnancy health optimization, which is especially crucial for women with underlying medical conditions that may exacerbate risks associated with either contraception or pregnancy.

c. **Abortion data collection**: The Branch annually publishes the only federal national report on abortion data, which has been produced by DRH since 1969, and provides technical support to jurisdictions for abortion reporting (e.g., sample of standardized case reporting form, data collection system infrastructure, data processing).

d. **IVF surveillance:** The Branch works to enhance women's chances of successful IVF pregnancies through the National ART Surveillance System (NASS). Since 1995, NASS has tracked IVF activities annually for every clinic in the United States under a congressional mandate, offers critical IVF data to clinics, and supports families seeking assistance with infertility. The Branch provides

scientific and technical support (e.g., survey development, data collection system infrastructure, standardized methodology, data processing) to over 500 IVF clinics across the United States and its territories to annually collect and publish data for public use on patient and clinical characteristics and pregnancy and infant outcomes. Data from clinics represents approximately 95,000 live births annually in the United States. NASS is the only standardized state-specific and clinic-specific data source for IVF and is crucial for informing clinicians, patients, and public health policies aimed at increasing access to IVF and improving maternal and infant health.

12. The Field Support Branch assists domestic and international health agencies in epidemiologic monitoring and program evaluation, surveillance, emergency preparedness, and translation of findings by providing technical assistance, subject matter expertise, capacity building, partnership, and workforce development in reproductive, maternal, infant, and perinatal health programs. The Field Support Branch includes three teams: Maternal and Child Health Epidemiology Team, Emergency Preparedness and Response Team, and Global Reproductive Health Evidence for Action Team. The Field Support Branch's activities are authorized by Congress in the Public Health Service Act (PHSA), the Pandemic and All-Hazards Preparedness Act, Pub. L. 109-417, and the Safe Motherhood Act, 42 U.S.C. § 247b-12. Key activities in the Field Support Branch include:

a. **Maternal and child health epidemiology support to states:** The Branch has provided direct assistance to states since 1986 through the assignment of CDC maternal and child health epidemiologists as field assignees. These epidemiologists serve in states across the country by analyzing public health

data, advising leadership on applying evidence to programs, providing subject matter expertise, overseeing scientific projects, training other epidemiologists, improving quality and use of data systems, and evaluating public health programs. Field assignees are requested by states, who fund 80% of the salary and benefits for their field assignee, with the other 20% funded by CDC.

b. **Emergency preparedness and response:** The Branch builds capacity at national, state, and local levels for infectious disease outbreaks, natural disasters and other public health emergencies through training, leadership development, and practice exercises to optimize maternal and infant health. Staff identify, measure, and address the special needs of reproductive-aged women, pregnant women, and postpartum women and infants during emergency responses of emerging and re-emerging infections (e.g., COVID-19, Oropouche virus, measles) as well as environmental concerns (e.g., extreme heat, natural disasters, radiation exposure).

c. **Global maternal health:** The Branch improves global maternal and infant health by strengthening the evidence base and public health capacity. Staff established guidelines and pilot initiatives on maternal death surveillance and response and assessed the impact of interventions to increase access to emergency obstetric care.

The April 1, 2025 RIFs and Effects on DRH

13. On April 1, 2025, approximately 80 of 130 total DRH employees received RIF notices, including almost 60 scientists and medical officers. RIFed employees were placed on administrative leave immediately until their expected termination at the end of day on

June 2, 2025. None of the RIFed DRH employees have been permitted to continue work of the division during this time.

14. The RIFs effectively shut down all but one branch of DRH. All civil service employees of the Office of the Director and two of the three branches (Field Support Branch and Women's Health and Fertility Branch) were placed on administrative leave. Only the employees of the Maternal and Infant Health Branch remain employed by CDC.

15. Prior to the April 1 RIFs, most of the probationary employees and contractors in DRH's Office of the Director, Women's Health and Fertility Branch, and Field Support Branch were terminated on or before April 1, 2025.

The April 1 RIFs Have Devastated DRH's Work

16. With the exception of the work of the Maternal and Infant Health Branch, the RIFs have effectively halted all of DRH's work because there is no one left in the Division to carry it out. This includes many of DRH's statutorily mandated functions.

17. The April 1 RIFs have had an especially damaging effect on DRH surveillance systems. By eliminating the Women's Health and Fertility Branch, long-standing surveillance activities ceased that are vital for the health, safety, and well-being of families, mothers, and infants. PRAMS data for 2025 births is not being collected, data for 2024 births will be released to states in a raw and unusable format, and historical data from 1988-2023 are no longer available from CDC for policymakers and researchers to use. Notably, states and jurisdictions own their PRAMS data and contractually obligated functions with states are not occurring. The investment put into establishing this system and collecting this data to improve maternal and infant health outcomes is now wasted. In addition, there will no longer be continuous and systematic monitoring of scientific evidence on contraceptive safety or updated clinical

contraception guidance for health care providers, jeopardizing the health and safety of 47 million women in the United States who use contraception. The annual abortion data collection report by CDC has also ceased, eliminating the only federal source of data on the topic that has been published for over 50 years. Furthermore, data collection on IVF procedures has ceased, meaning critical surveillance data that informs procedural, safety, and ethical guidance for families seeking assistance with infertility is gone.

18. The April 1 RIFs have also eviscerated DRH's field work. Because the entirety of the Field Support Branch was terminated, epidemiologists assigned to work in the field as CDC employees in 11 state health departments have been removed from their posts. States immediately and without warning lost maternal and child health epidemiology leadership and progress on ongoing, often state-mandated, projects was halted. Data produced only by programs within DRH (e.g., PRAMS, abortion data collection) is used by states to prioritize and implement maternal and child health improvement efforts in their jurisdictions. Without these data and staff to lead needs assessments and data analysis with state-level data, states will not know what health conditions or outcomes to prioritize nor will they be able to track progress on their efforts. Additionally, immediate impacts to state and local jurisdictions include the loss of emergency preparedness and response capacity-building programs that DRH had funded since 2018; the removal of critical tools and resources for maternal and infant health emergency preparedness hosted on the CDC website; and the loss of CDC obstetrical and neonatal expertise available to public health and clinical staff during public health emergencies. Together, these losses will result in jurisdictions being less ready to support pregnant and postpartum women and infants during public health emergencies, including the current measles outbreak in the United States.

19. DRH's work is not and cannot be duplicated elsewhere in CDC or the broader Department of Health and Human Services (HHS). While HRSA's Maternal and Child Health Bureau (MCHB) administers a range of impactful programs, CDC's focus on surveillance and prevention in order to advance the scientific evidence base of public health risks, interventions, and outcomes related to maternal and infant health, and on providing clinical prevention and treatment guidance is distinct. For example, PRAMS maternal and infant health surveillance work is different from, but complements, HRSA MCHB program administration functions. PRAMS provides high quality data that are needed for states to conduct maternal and child program needs assessment and justification for their HRSA Title V block grants, with many of the PRAMS health indicators used by HRSA MCHB as their maternal and child health performance and outcomes measures. Through PRAMS, HRSA MCHB is able to evaluate the impact of their program funding on improving maternal and infant health. Furthermore, CDC's DRH is the only federal program to directly support states with assigned field epidemiologists, with states typically using funds from the HRSA Title V block grant to fund placement of the field assignees. While MCHB recognizes the importance of emergency preparedness on optimal maternal and infant health by requiring Title V block grant recipients to report out annually on jurisdictional MCH planning and preparedness, CDC conducts the research to determine the impact of public health emergencies on maternal and infant health, develops scientific tools and resources and clinical prevention and treatment guidance, and provides clinical consultations to health providers. Other groups within HHS and CDC specialize in emergency preparedness and response for different hazards (e.g., infectious diseases, natural disasters) and other populations (e.g., children, people with disabilities), but DRH is the only division in the federal government with all-hazards emergency preparedness and response expertise focusing on maternal and

infant health. Additionally, other DRH programs that were abolished by April 1 RIFs are not performed by any other federal agency, including within CDC: contraception guidelines on safety of contraceptive use, abortion data collection, and IVF surveillance.

20. Moreover, without staff in its Office of Director and two of its three branches, DRH does not stand ready to respond to the public health challenges that will emerge in the coming months and years for women, infants, and families. For example, staff in the impacted areas of the Division have been called upon to provide crucial subject-matter expertise and leadership in public health responses, including those involving infectious agents that necessitate special considerations for reproductive-aged, pregnant, or postpartum women, and infants (e.g., measles, influenza, Zika virus). DRH's field assignees frequently serve as on the ground experts to relay information to CDC on emerging issues related to maternal and infant health in their states and jurisdictions, such as observed increases in deleterious health exposures or outcomes, often before these exposures or outcomes are observed in other states or in national data. With many public health emergencies increasing in frequency (e.g., infectious pandemics, extreme heat events) and severity (e.g., wildfires, tropical storms), the elimination of DRH and its scientific, clinical, and capacity-building work will have a harmful impact on the ability of CDC, states, and jurisdictions to prepare for and respond to the needs of pregnant and postpartum women and infants during emergencies. Women and infants will be less safe and emergency/disaster-related morbidity and mortality may rise.

Conclusion

21. The April 1 RIFs have incapacitated DRH. Without DRH's expertise, no other agency within CDC, HHS, or the federal government will carry out DRH's functions aimed at promoting reproductive, maternal, and infant health.

___"/s/ Jane Doe 3"_____
Jane Doe 3

Date: 2025.05.17